TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Pacific Employers Insurance Co

MFDR Tracking Number
M4-16-3712-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,174.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid all billed charges pursuant to the Medicare Fee Guidelines. The value of the procedure codes not paid, and the subject of this dispute, were packaged into the payment of other services performed on the same date of service. No additional monies are owed to Requestor."

Response Submitted by: Downs ♦ Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2016	Outpatient hospital services	$1,174.68	$1,174.67

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers compensation jurisdictional fee schedule adjustment

- W3
- 193
- MOPS
- ZE10

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement in the amount of $1,174.68 for outpatient hospital services rendered on March 22, 2016.

   The insurance carrier reduced the disputed services with reduction codes, P12 – "Workers compensation jurisdictional fee schedule adjustment," and 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The Division finds that the outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

2. The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are found below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

   - **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.7989	40% non-labor related	Payment	Maximum allowable reimbursement
72265	5525	Q2	$667.93	$667.93 x 60% = $400.76	$400.76 x $0.7989 = $320.17	$667.93 x 40% = $267.17	$320.17 + $267.17 = $587.34	$587.34 x 200% = $1,174.68
72132	5572	Q3	$347.72	$347.72 x 60% = $208.63	$208.63 x 0.7989 = $166.67	$347.72 x 40% = $139.09	$166.67 + $139.09 = $305.76	$305.76 x 200% = $611.52
							Total	$1,786.20

The status indicators listed above are defined as follows:

> *Q2 - T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim.* Review of the submitted medical claim finds no other claim with a "T" status indicator. Therefore, this line is separately payable.
>
> *Q3 - When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.* Review of the submitted medical claim finds the criteria for composite payment were not met. Therefore, this line is separately payable.

The remaining services are classified as follows:

- Procedure code 36415 has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code 80048 has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code 85027 has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code 85610 has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3."

Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.

- Procedure code 85730 has a status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." Review of the medical claim finds claim lines with Q2 and Q3 status indicators. No separate payment recommended.
- Procedure code Q9967 has status indicator N denoting packaged codes with no separate payment.
- Procedure code J2001 has status indicator N denoting packaged codes with no separate payment.

3. The total allowable reimbursement for the services in dispute is $1,786.20. This amount less the amount previously paid by the insurance carrier of $611.53 leaves an amount due to the requestor of $1,174.67. This amount is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,174.67.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,174.67, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 26, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.